

**Vendor Approver Certification**

ADP 100178 (Rev 7/06)

For Granting Access to the CalOMS Treatment Data System

**ADP Approved**Date      Approver**Vendor Name:** \_\_\_\_\_

To ensure the confidentiality of county/direct provider CalOMS Treatment data, the Department of Alcohol and Drug Programs (ADP) requires that each designated vendor identify a primary and a secondary contact to be responsible for approving requests for ITWS access to confidential county/direct provider confidential patient data in the CalOMS Treatment data system. Please complete and fax this form to ADP at (916) 323-0653. If you have questions about this form, please call (916) 327-4556 or e-mail [CalOMSHelp@adp.state.ca.us](mailto:CalOMSHelp@adp.state.ca.us).

**Primary Vendor Approver:****Please print all information**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Primary Approver's Signature: \_\_\_\_\_

(Signer acknowledges having read the attached Confidentiality Statement to Users of the Information Technology Web Services (ITWS).)

**Secondary Vendor Approver:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Secondary Approver's Signature: \_\_\_\_\_

(Signer acknowledges having read the attached Confidentiality Statement to Users of the Information Technology Web Services (ITWS).)

**Vendor for the Following Counties/Direct Providers:**

(Please indicate the appropriate two-digit County code number(s) or six-digit Direct Provider code number(s))

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Vendor Executive Officer Certification:**

I hereby certify that this organization is a vendor for the above-named counties/direct providers and designate the individuals identified above to have independent authority to approve ITWS access requests to specific confidential county/direct provider CalOMS Treatment patient data. ADP may rely on approvals, denials, and changes made by these individuals in its processing of access requests for the above listed counties'/direct providers' data. As changes occur to the above approving contacts (name, phone, e-mail or county/direct provider), I will complete a new certification and fax it to ADP. Also, I acknowledge reading the attached Confidentiality Statement to Users of the Information Technology Web Services (ITWS).

**By:** \_\_\_\_\_ (signed and printed)      **Date:** \_\_\_\_\_**Title:** \_\_\_\_\_